RAI Panel Q&As for August, 2011

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Chapter 1

Chapter 2

1. **Question**: An MDS was submitted as both admission and 5 day. It was to have been an admission only. Resident is NOT a Medicare resident. Does the record need to be inactivated and submitted as an admission or, since the resident is not Medicare can the record be left as is?
   Answer: For accuracy, that assessment should be inactivated and just the Admission assessment submitted. If not, their next assessment's validation report will contain error messages and this goes against CMS rules which are that only required assessment be submitted to the QIES ASAP.
   AHFSA Panel – August, 2011

2. **Question**: My question is how does the End of Therapy OMRA and the Start of Therapy OMRA affect billing for a resident admitted 5/17/11 Med A. 5 day assessment done 5/24, RUG RHA 10, covers 5/17 to 5/30/11; 14 day assessment done 5/30, RUG RHA covers 5/31/ to 6/15/11. Therapy stopped due to illness, last day of therapy 6/1/11. End of Therapy OMRA ARD 6/4/2011, RUG LB1 04. 30 day assessment done 6/14/2011 (still off therapy) RUG LB1 30, would cover 6/16 to 7/15/2011. Therapy resumed 6/15/2011, Start of Therapy OMRA done 6/21/2011 RUG RMA 02. 60 day assessment done 7/12/2011 RUG RHL40,would cover 7/16 to discharge on 7/23/2011.
   Answer: Billing for these days would be as follows: Bill RHA from 5/17-6/1. Starting 6/2, the EOT OMRA will take effect and you would bill LB1 through 6/14. The 30 day assessment would be done, but you would not bill at LB1 because the SOT would set the rate at RMA starting June 15 which was the first day of therapy. That RUG would be in effect until 7/16 when the 60 day assessment was completed and that would pay either until the end of the stay or until the next scheduled or unscheduled assessment.
   AHFSA RAI Panel – August, 2011 / CMS – September 2011

Chapter 3

1. **Falls Question**: Looking at the definition of falls in Section J. it states an ***unintentional*** change in position. If a resident intentionally throws him/herself to the floor, would this not be considered a fall, due to intent? I've read the material about falls in the RAI Manual and do not see where this question is addressed
   Answer: The MDS 3.0 manual is collecting fall information related just to unintentional falls as described. If a resident is intentionally throwing themselves to the floor, it would appear the resident is displaying a behavior that may cause self-harm if not addressed. The behavior would be coded in **E0200 C** (frequency), **E0300** Overall Presence of Behavioral Problems and **E0500** Impact on Resident and **E0600** Impact on others. Coding should be based on whether the symptoms occurred and not based on the interpretation of the behavior's meaning. The emphasis of Section E of the MDS 3.0 manual is identifying behaviors, having follow-up evaluation and care plan interventions that can be developed to improve the symptoms or reduce their impact.
   RAI Panel – August 2011

2. **J0100 - Pain Question:** Can drugs such as tricyclic antidepressants, or anticonvulsants with approved uses for pain be coded in J0100 if they are prescribed for pain? Or does the drug have to be classified solely as an analgesic? Additionally, does an NSAID 'treat the underlying condition' for something like arthritis?
   Answer: If the medications are prescribed by the physician (or other authorized prescriber) specifically for pain, then yes, they can be coded. The MDS 3.0 manual directs, on page J-1, that the assessor should determine all interventions for pain provided to the resident during the 5-day look-back period. Pain medication regimen is defined as pharmacological agents prescribed to relieve or prevent the recurrence of pain and it includes all medications used for pain management by any route and any frequency during the look-back period. These include oral, transcutaneous, subcutaneous, intramuscular, rectal, intravenous or intraspinal delivery. Medications such as steroids or chemotherapy that are used to treat an underlying condition would not be included even though they may lead to pain reduction. Aspirin, Ibuprofen, or Naproxen are examples of

nonsteroidal anti-inflammatory drugs (NSAIDs) that can relieve arthritis pain but will not be treating the underlying condition.
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3. **Section L -Question**: In section L, the intent statement reads "to record dental **problems** present in the 7-day look back period;" and coding instructions read "check all that apply." Item L0200B states to check if the resident has no natural teeth or tooth fragment(s) (edentulous): if the resident is edentulous or lacks all natural teeth or parts of teeth. I had several people question if L0200B should be checked if the resident has no natural teeth, but has dentures. Can you clarify?
Answer: Coding for dentures that are broken or loosely fitting will be in Item L0200A, but there is no item in Section L that is just asking whether the resident has dentures. Item L0200B is not collecting information related to dentures. Coding this item will reveal whether the resident has no natural teeth (edentulous) or tooth fragments present meaning a very large cavity, tooth broken off or decayed to the gum line, or broken teeth from a fall or trauma. Under Steps for Assessment, the #3 step directs what to do if the resident has dentures or partials and the need to examine for chips, cracks and cleanliness. The MDS manual states also that mouth or facial pain coded in L0200F could also be coded in Section J, if it occurred in the 5 day look-back period for these items. The look-back for Section L is 7 days, but Section J-pain is only a 5 day look-back.
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4. **MO900A - Question**: We recently had a call from a provider regarding a pressure ulcer that developed and healed between an annual assessment and a quarterly assessment (according to the provider the wound wasn't present when they completed the annual assessment); they inquired as to how to code M0900 on the quarterly assessment currently being completed. Upon researching their question on Pg. M-27 under M0900: Healed Pressure Ulcers, Steps for Assessment we identified the following statements: "*Complete on all residents including those without a current pressure ulcer*. Look-back period for this item is the ARD of the prior assessment. If no prior assessment (I.e., if this is the first OBRA OR PPS assessment), do not complete this item. *Skip to M1030".* The assessment form (Item Set) does not reference the look-back period of the ARD of the prior assessment*.* The coding instructions for M0900A state "Enter 0**:** If there were no pressure ulcers on the prior assessment and skip to Number of Venous and Arterial Ulcers item (M1030). Enter 1**:** if there were pressure ulcers noted in the prior assessment. Coding instructions for M0900B, C and D state: Enter the number of pressure ulcers that have healed since the last assessment for each stage 2 through 4. Enter 0**:** if there were no pressure ulcers at the given stage or no pressure ulcers that have healed. *CMS San Antonio conference slide 223 regarding M0900: Healed Pressure Ulcers states the "Look-back period is the ARD of the prior MDS to the current ARD".* How would the provider code M0900 in the scenario above?
Answer: The panel agrees with what you have stated directly from the MDS 3.0 manual in your question that if there is no pressure ulcer noted on the prior assessment, the provider should code M0900A as a "0" and skip to Number of Venous and Arterial Ulcers in item M1030 and that is the answer. This is correct as the manual states on page M-27. There were no pressure ulcers noted on the last/prior assessment which was an Annual Assessment. There is no need to go further with what the manual says about coding Section M past the instructions for M0900A as it is not relevant to the question. The current manual also says that the look-back period for M0900 is the ARD of the prior assessment and that medical records should be reviewed to identify whether any pressure ulcers have completely closed by the ARD (A2300) of the current assessment.
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5. **M0140 Question**: Can a healing tracheostomy wound be coded as a surgical wound in Section M? The person no longer needs the tracheostomy, the cannula has been removed and it has been left to heal.
Answer: A healing tracheostomy wound can be coded as a surgical wound in Section M at M1040 until the wound is healed. As long as the staff and/or the resident is providing care, the tracheostomy that has not yet healed, can also be coded as tracheostomy care in O0100E.
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6. **O0100H - Question**: We have a resident that goes to dialysis 3 times a week. We know we cannot count any IV medication that is given during dialysis but have a situation that we have not previously come across. This resident has an infected shunt and after she receives her dialysis, the dialysis center gives her an IV antibiotic while she is still there. This is AFTER she is finished with dialysis, not during, but while she is still at the center
Answer: The coding of the IV medication given at the dialysis center after the dialysis has been completed will most likely be billed by the Dialysis center and doesn't seem to fit under O0100H -2 While a Resident. Coded this way, the facility would have an increase in the RUG group, but in reality the Dialysis Center will most likely be billing for this ATB IV and two entities cannot be paid for the same thing in MDS 3.0. At this time, until CMS makes a final decision on matters such as this, you are advised NOT to code it under O0100H -2 and instead just do not code the IV ATB given at the Dialysis Center but document it in the medical record.
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7. **O0100M - Question:** A RHCF would like to create an isolation suite, wherein patients can get their rehab (on Medicare or Medicaid) right in their room, with all equipment available in the room. There would also be a dedicated corridor adjacent to the room where they can walk a good distance, without contact with others. That corridor would also be available to another isolation suite that is adjoining. These two isolation patients would use the corridor for walking at different times of day, each entering the corridor from their own room. No one else would ever use the corridor. Can they code "isolation" on the MDS, if all these conditions (and all other requirements) are met? The questioner states that she has reviewed all of Section O in the manual, and the info on the CDC link and the NAIC article link listed on page O-5 of the most updated version of the manual, as well as reviewed the recently updated guidelines, and the related sites that are part of our state. Is this not part of the facility's responsibility to decide if it meets the coding criteria in the manual, by making sure that these proposed suites comply with the manual when coding isolation precautions?....or is there more to it from your perspective? Of course, the proposed suites would need to go through the CON process as well.
   Answer: The panel agrees that this question is the facility's responsibility and is reluctant to answer this question. A facility needs to be directed to the information in the MDS 3.0 manual on pages O-4 and O-5, current as of July 2011. The panel cannot answer a hypothetical question for a facility/unit that is not yet constructed. When there is a resident and an actual situation that pertains to strict isolation for a resident with an active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission, the panel will assist. The panel agrees that this question might be better directed to the CMS Regional Office and also to the State in which it is located for certification and for the CON approval.
   AHFSA RAI Panel – August, 2011

Chapter 4

Chapter 5

Chapter 6

1. See question under Chapter 2 for billing with SOT and EOT OMRAs.

OTHER:

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